

BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of ARM)
37.82.101, and 37.82.701 pertaining to)
Medicaid eligibility)

NOTICE OF PUBLIC HEARING
ON PROPOSED AMENDMENT

TO: All Interested Persons

1. On August 17, 2006, at 11:00 a.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed amendment of the above-stated rules.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who need an alternative accessible format of this notice or provide reasonable accommodations at the public hearing site. If you need to request an accommodation, contact the department no later than 5:00 p.m. on August 7, 2006, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970; e-mail dphhslegal@mt.gov.

2. The rules as proposed to be amended provide as follows. Matter to be added is underlined. Matter to be deleted is interlined.

37.82.101 MEDICAL ASSISTANCE, PURPOSE AND INCORPORATION OF
POLICY MANUALS (1) remains the same.

- (2) The department adopts and incorporates by reference the state policy, namely the Family Medicaid Manual and the ~~SSI Aged/Blind/Disabled (ABD)~~ Medicaid Manual manuals governing the administration of the ~~m~~Medicaid program ~~effective dated July 1, 2005~~ 2006. The Family Medicaid Manual, the ~~SSI ABD~~ Medicaid Manual, and the proposed manual updates are available for public viewing at each local Office of Public Assistance or at the Department of Public Health and Human Services, Human and Community Services Division, ~~4400 Broadway~~ 111 N. Jackson St., P.O. Box ~~202952~~ 202925, Helena, MT 59620-~~2952~~ 2925. The proposed manual updates are also available on the department's website at www.dphhs.mt.gov/legalresources/proposedmanualchange.shtml.

AUTH: 53-2-201, 53-6-113, MCA

IMP: 53-6-101, 53-6-131, 53-6-141, MCA

37.82.701 GROUPS COVERED, NONINSTITUTIONALIZED FAMILIES AND
CHILDREN (1) Medicaid will be provided to:

(a) remains the same.

(b) individuals who have been receiving assistance in the nonmedically

needy family ~~may~~ Medicaid program and whose assistance is terminated because of earned income. These individuals may continue to receive ~~may~~ Medicaid for any or all of the 12 calendar months immediately following the month in which nonmedically needy family ~~may~~ Medicaid is last received, providing:

(i) in cases where assistance was terminated due to earned income, a member of the assistance unit continues to be employed during the 12 months; however, eligibility may continue even though no member of the assistance unit is employed if there was a good cause as defined in ~~ARM 37.78.508~~ the family-related Medicaid manual, section 1509-1, as incorporated by reference in ARM 37.82.101, for the termination or loss of employment;

(ii) remains the same.

(iii) there continues to be an eligible child in the assistance unit. This coverage group is known as the "~~extended medicaid group~~ family-extended".

(c) individuals under age 19 who live with a specified caretaker relative as defined in ~~ARM 37.78.103~~ the family-related Medicaid manual, section 305-1, as incorporated by reference in ARM 37.82.101, and who meet all other eligibility requirements;

(d) a pregnant woman whose pregnancy has been verified and whose family income and resources meet the requirements listed in ARM 37.82.1106, 37.82.1107, and 37.82.1110. This coverage group is known as the "qualified pregnant woman group";

(i) The unborn child shall be considered an additional member of the ~~assistance~~ filing unit for purposes of determining eligibility.

(e) a pregnant woman whose pregnancy has been verified, whose family income does not exceed 133% of the federal poverty guidelines, and whose countable resources do not exceed \$3,000. This coverage group is known as the "~~poverty level pregnant woman~~ pregnancy group";

(i) The unborn child shall be considered an additional member of the ~~assistance~~ filing unit for purposes of determining eligibility.

(ii) through (g)(i) the same.

(h) a child born on or after October 1, 1983, who has attained age six but has not yet reached age 19, whose family income does not exceed 100% of the federal poverty guidelines and whose countable resources do not exceed ~~\$3,000~~ \$15,000. This coverage group is known as the "~~poverty six child~~ child-age six to 19 group";

(i) a child through the month of the sixth birthday whose family income does not exceed 133% of the federal poverty guidelines and whose countable resources do not exceed ~~\$3,000~~ \$15,000; this group is known as the "~~poverty level child~~ child-under age six group";

(j) through (k) remain the same.

(l) needy caretaker relatives as defined in ~~ARM 37.78.103~~ the family-related Medicaid manual, section 305-1, as incorporated by reference in ARM 37.82.101, who have in their care an individual under age 19 who is eligible for ~~may~~ Medicaid, and whose countable income does not exceed the state's family ~~may~~ Medicaid standards as defined in the ~~family-related~~ may Medicaid manual, section 002;

(m) a child through the month of the child's 19th birthday, who lives in a household whose income and resources do not exceed the medically needy income and resource standards specified in ARM 37.82.1106, 37.82.1107, and 37.82.1110,

~~regardless of whether provided that the child does not~~ lives with a parent or specified caretaker relative as defined in ~~ARM 37.82.103~~ the family-related Medicaid manual section 305-1. This coverage group is known as the "~~Ribicoff~~ child-medically needy group";

(n) women, under the age of 65 who have been screened through the Montana Breast and Cervical Health Program who:

(i) and (ii) remain the same.

(iii) have countable income that does not exceed 200% of the federal poverty level at the time of screening and enrollment into the Montana Breast and Cervical Health Program; and

(iv) are not eligible for any other nonmedically needy ~~m~~Medicaid coverage group. This coverage group is known as "breast and cervical cancer treatment"; and

(o) through (2) remain the same.

~~(3) Medicaid will continue for one year for newborn children providing:~~

~~(a) the mother was eligible for and receiving medicaid at the time of the newborn's birth;~~

~~(b) the mother of the newborn remains eligible;~~

~~(c) the child remains in the same household as the mother; and~~

~~(d) the mother remains a Montana resident.~~

~~(4)~~ (3) Medicaid may be provided for up to three months prior to the date of application for individuals listed in (1)(a), (1)(c), (1)(d), (1)(g), (1)(h), (1)(i), (1)(j), (1)(k), (1)(l), and (1)(m) if all financial and no-financial eligibility criteria are met as of the date medical services were received in each of those months.

AUTH: 53-4-212, 53-6-113, MCA

IMP: 53-4-231, 53-6-101, 53-6-131, 53-6-134, MCA

3. The Montana Medicaid program is a joint federal-state program that pays medical expenses for eligible low-income individuals. To qualify for the Montana Medicaid Program, an individual must meet the eligibility requirements set forth in ARM Title 37, chapter 82. Additionally, the Family Medicaid Manual and the Aged/Blind/Disabled (ABD) Medicaid Manual, formerly known as the SSI Medicaid Manual set forth information about the eligibility requirements for Medicaid that is more detailed than that in administrative rules. These state policy manuals are published by the department to provide guidance to employees of the local offices of public assistance who determine eligibility for Medicaid.

ARM 37.82.101 adopts and incorporates by reference the Medicaid policy manuals. By incorporating these manuals into the administrative rules, the department gives interested parties and the public general notice and an opportunity to comment on policies governing Medicaid eligibility. Additionally, as a result of the incorporation of the manuals into the administrative rules, the policies contained in the Family Medicaid Manual and the ABD Medicaid Manual have the force of law in case of litigation between the department and a Medicaid applicant or recipient concerning the applicant or recipient's eligibility for Medicaid.

ARM 37.82.101 currently adopts and incorporates by reference the Medicaid policy

manuals dated July 1, 2005. On June 12, 2006, the department filed a Notice of Public Hearing on Proposed Amendment, MAR Notice No. 37-385, which proposed amending ARM 37.82.101 to adopt and incorporate by reference the Medicaid policy manuals dated July 1, 2006. In MAR Notice No. 37-385 the department discussed certain changes in the manuals dated July 1, 2006 and explained why these changes were necessary.

The department now proposes to further amend its Medicaid policy manuals to make additional changes contained in the manuals dated July 1, 2006 that are not addressed in MAR Notice No. 37-385. The proposed amendments to ARM 37.82.101 are therefore necessary in order to incorporate into the Administrative Rules of Montana the revised sections of the policy manuals and to permit all interested parties to comment on the department's policies and to offer suggested changes. It is estimated that changes to the Family Medicaid and ABD Medicaid Manuals could affect 82,147 Medicaid recipients. Manuals and draft manual material are available for review in each local office of public assistance and on the department's website at www.dphhs.mt.gov. Following is a brief overview of the changes being made to each manual section for the Family Medicaid Manual and the ABD Medicaid Manual.

Family Medicaid Manual

Fiscal impact based on the changes below is expected to be zero, unless noted otherwise.

FMA 001 General Resource Limitation It is necessary to update this manual section to reflect that the resource limit for children's poverty-related Medicaid (known as Child-Under Age 6 and Child-Age 6 to 19), which is currently \$3,000, will be increased to \$15,000 beginning July 1, 2006. This increase in the resource limit is necessary to implement House Bill 552 passed by the 59th Montana Legislature and codified at section 53-6-113, MCA, which is effective July 1, 2006. It provides that the department may not use a resource limit below \$15,000 for children's poverty-related Medicaid. Increasing the resource limit is expected to allow an additional 3775 children to receive Medicaid at an estimated cost of \$7,761,272 (3775 children x \$168.24 average monthly cost x 12 months) for SFY 2007. The state share is estimated to be \$1,824,917 to be funded with State Special Revenue from I-149, the Tobacco Initiative, which increased taxes on cigarettes and tobacco products.

FMA 103-4 Verification and Documentation This section is being updated to reflect that income and resources must be verified at application, redetermination, and anytime a change is reported. Current policy is that income and resources must only be verified at application and redetermination; and that "client statement" is sufficient at all other times. This change is necessary for two reasons. The first is that state Medicaid reviewers are discovering eligibility errors caused by not requiring verification of changes in income and/or resources. The current Medicaid error rate is approximately 13%. Federal Medicaid Quality Control is slated to begin in 2008 in Montana. At that time, Montana will be expected to have an error rate of

3% or less. Implementing this change now will allow time for the state to lower the current error rate prior to federal reviews taking place. The second reason for this change is in preparation for the new Medicaid eligibility system, CHIMES (Combined Healthcare Information and Montana Eligibility System). CHIMES is a rules-based system and cannot differentiate between when it is appropriate to allow "client statement" and when it is necessary to require other verification.

Other minor changes were also made to remove coding specific to the current eligibility system, TEAMS, in preparation for CHIMES and to clarify that an application cannot be denied for failing to provide verification until the application is at least 45 days old. Federal law provides that the state Medicaid agency generally must determine eligibility for family-related Medicaid within 45 days of the date of application. Since the state agency has 45 days to process the application, there is no reason to deny the application before the 45 days are up due to lack of verification. It is preferable to give the applicant the full 45 days to provide verification of information needed to determine eligibility.

FMA 400 Resources Overview It is necessary to update this manual section to reflect that the resource limit for children's poverty-related Medicaid (known as Child-Under Age 6 and Child-Age 6 to 19), which is currently \$3,000, will be increased to \$15,000 beginning July 1, 2006. This increase in the resource limit is necessary to implement House Bill 552 passed by the 59th Montana Legislature and codified at section 53-6-113, MCA, which is effective July 1, 2006. It provides that the department may not use a resource limit below \$15,000 for children's poverty-related Medicaid. Increasing the resource limit is expected to allow an additional 3775 children to receive Medicaid at an estimated cost of \$7,761,272 (3775 children x \$168.24 average monthly cost x 12 months) for SFY 2007. The state share is estimated to be \$1,824,917 to be funded with State Special Revenue from I-149, the Tobacco Initiative, which increased taxes on cigarettes and tobacco products.

FMA 1501-1 Reporting Changes This section has also been updated to reflect that income and resources must be verified at application, redetermination, and anytime a change is reported. This change is necessary for the same reasons as stated above, under FMA 103-4. This section is also being revised to clarify that changes affecting coverage level must also be timely reported and that the date the change is reported is used to determine retroactive eligibility for the higher coverage level. Family-related Medicaid has two coverage levels, basic Medicaid and full Medicaid. Basic Medicaid generally does not cover certain services that are covered by full Medicaid, such as dental and eyeglass services. Most adults receiving family-related Medicaid have basic coverage, but pregnant women are entitled to the higher level of coverage provided by full Medicaid during their pregnancy. Thus, the fact that a Medicaid recipient has become pregnant or is no longer pregnant is a change which would affect coverage level. The date a change resulting in a higher coverage level is reported determines when full Medicaid coverage begins.

For example, if a Medicaid recipient with basic coverage became pregnant in April but did not report her pregnancy until November, she would be entitled to full

Medicaid coverage retroactively for the three months prior to the month she reported the change, November. Thus, she would have full coverage beginning in August, although she could have had full coverage beginning in April if she had reported the change earlier. This policy is based on the federal rule that retroactive Medicaid coverage is available only for the three months immediately preceding the month of application. The recipient receiving basic Medicaid is in effect applying for the higher coverage level by reporting the change, so full Medicaid coverage can be granted retroactively for no more than three months prior to the month the change is reported. Minor corrections were made to correct form and notice numbers mentioned in the section.

ABD Medicaid Manual

Fiscal impact of the following proposed changes is expected to be zero. Although these changes include increases to the Medicare Savings Programs (poverty level based), these standards are required to match the federal standards as published. These increases do not result in an increase in the number of eligible individuals, but only retain eligibility for those already receiving these benefits, as any cost of living increases to Social Security benefits received by recipients of Medicare Savings Programs are disregarded when determining ongoing eligibility prior to the publishing of new federal poverty standards.

The following sections were updated to incorporate the 2006 federal poverty standards:

- MA 003 *Qualified Medicare Beneficiaries*
- MA 004 *Special Low Income Medicare Beneficiaries*
- MA 007 *Qualified Disabled Working Individuals*
- MA 010 *Poverty Guidelines*
- MA 012 *Qualifying Individuals (QI-1)*

The eligibility standards for these programs are based on the federal poverty standards as published by the U.S. Department of Health and Human Services annually and therefore must change when the federal standards change. The federal standards are revised annually to reflect increases in the cost of living. The higher eligibility standards do not result in an increase in the number of eligible individuals, but only retain eligibility for those already receiving these benefits.

MA 0-4 Glossary This section has been amended to clarify the definition of a dependent adult child to be an adult child who is financially dependent upon his/her parents, and is claimed on the parents' income tax return. The definition of home has been changed to clarify that only mobile homes actually being resided in are excluded as part of an individual's home. The previous definition implied that all mobile homes situated on the home real estate of an individual were eligible to receive the home exclusion. A definition of 'actuarially sound' has been added. These revisions are merely clarifications, not changes in policy and should, by themselves, have no fiscal impact. The fiscal impact is discussed in the policy

sections to which these definitions relate.

MA 001 *Categorically Needy Standard* This section has been updated to indicate that an individual in a residential medical institution is categorically needy for Medicaid only if their income is at or below the Supplemental Security Income (SSI) payment amount of \$30 for an institutionalized individual. Individuals in residential medical institutions who have income over \$30, but less than the Medically Needy Income Level of \$525 are considered medically needy without an incurment. This change has no fiscal impact, as it will not affect who is eligible for Medicaid and who is not eligible for Medicaid in a residential medical institution. It only affects whether a person is considered medically needy or categorically needy for reporting to the Centers for Medicare and Medicaid Services.

MA 005 *Nursing Home Residents* When a married individual enters a nursing home or other institution and applies for Medicaid, 42 U.S.C. 1396r-5 provides special rules governing the counting of income and resources to ensure that the applicant's spouse who is still residing in the community, known as the community spouse, retains enough income and resources to meet the community spouse's own needs. The community spouse income maintenance allowance is the amount of income the community spouse is entitled to keep for that spouse's needs. The Basic Shelter Allowance and Basic Needs Standard are used in determining the community spouse income maintenance allowance. Section MA 005 is being updated to include the increased Basic Shelter Allowance and Basic Needs Standard published by the Centers for Medicare and Medicaid Services (CMS). The increased Basic Shelter Allowance and Basic Needs Standard will be used as of July 1, 2006. There is expected to be no fiscal impact because the increases merely address inflationary increases in the cost of living. This section has also been corrected to indicate that the categorically needy standard for a person living in an institution is \$30, rather than \$603. The categorically needy standard is the SSI Standard Payment Amount, which varies by a person's living situation, and this had not been reflected in past policy. This change does not have any fiscal impact because coverage levels are the same whether a person is categorized as medically needy or categorically needy, and their liability toward cost of care in a facility is also not impacted by these standards.

MA 402-1 *Countable and Excluded Resources* This section has been updated to incorporate changes mandated by the Deficit Reduction Act (DRA) of 2005. The state will now only exclude as resources annuities that belong to the Medicaid recipient, and not those owned by deemed parents or ineligible or community spouses. Annuities purchased after February 8, 2006 for the benefit of either a nursing home/waiver recipient or a community spouse must make the state of Montana Medicaid program a primary residual beneficiary, with only a community spouse or minor or blind/disabled child allowed to be named in a position superior to the State of Montana Medicaid Program. Any annuity purchased after that date that is not amended will be treated as an uncompensated asset transfer, and a penalty will be imposed against the nursing home spouse, even if the community spouse owns the annuity and the 90-day transfer period for spousal impoverishment has

expired. The financial impact of this change is included in the explanation in MA 404-1 below.

The home exclusion has changed in accordance with section 6014 of the DRA which provides that an individual shall not be eligible for nursing home and home and community based services if the individual's equity interest in the individual's home exceeds \$500,000. Thus, this section is being changed to say that home equity of only \$500,000 is excluded for applicants for or recipients of nursing home and home and community based services. Any additional equity is countable as a resource. There remains no limit on the home equity exclusion for Medicaid applicants and recipients who are not seeking coverage for nursing home care or home and community based services. The DRA provides that the \$500,000 limit will be adjusted annually to account for inflation beginning in 2011. This change should affect few individuals at present time. One group that will be affected is individuals who are temporarily in a nursing facility (i.e., have been in the facility for six months or less), because they may qualify for the home exclusion based on the possibility that they may return to the home. Individuals who are permanently residing in a facility (i.e., have been residing there for more than six months) are not eligible for the home exclusion, so this change in the law will have no effect on them. The other group that will be affected is individuals who have a spouse or other family member residing in the home, and whose home equity exceeds the \$500,000 limit. We anticipate this will primarily be those whose homes are on a farm or ranch. The agency believes this may impact as many as 20 individuals per year, or cost savings of \$381,740 total annually, or a State General Fund savings of \$103,069.80. The Deficit Reduction Act of 2005 requires this change.

Another change in policy mandated by the DRA relates to the purchase of a life estate in another individual's home. Section 6016(d) of the DRA provides that the purchase of a life estate in another's person's property by a Medicaid applicant or recipient within the look back period will result in an uncompensated asset transfer penalty unless the applicant or recipient resides in the home for a period of at least 12 full months after the date of purchase of the life estate. This particular 'estate planning' strategy has not been used, to our knowledge, in Montana. Therefore, we do not believe that this change will have any fiscal impact on the state budget.

Section 6016(c) of the DRA also provides that a loan given by a Medicaid applicant or recipient will be considered an uncompensated transfer of assets unless the repayment plan is actuarially sound, provides for payments to be made in equal amounts during the term of the loan with no balloon payment at the end and does not provide for cancellation of the loan upon the death of the applicant. Section 6016(c) further specifies that the value of such an uncompensated transfer for determining the period of time a Medicaid applicant will be ineligible due to the transfer will be the outstanding balance on the loan as of the date the individual applies for Medicaid nursing home or home and community based waiver services. Montana has treated loans that do not meet specific criteria as uncompensated asset transfers for some time, so the manual is merely being revised to specify that the federal criteria will be used to determine what loans will be considered

uncompensated transfers and to incorporate the federal method for determining the value of the transfer. The change in federal law simply supports the department's existing policy, and this change therefore should have no fiscal impact.

Currently basic maintenance items (household goods and personal effects) with a value of \$2,000 or less are not counted a resource to a Medicaid applicant, but the value of any basic maintenance items over \$2,000 is counted. This section is being revised to provide that the resource exclusion for basic maintenance items will no longer be limited to \$2000 in value. This change is being made because the Supplemental Security Income (SSI) program has changed its policy to eliminate the \$2,000 limit on the exclusion of basic maintenance items. The departmental rules governing eligibility for ABD Medicaid adopt by reference the SSI regulations regarding the treatment of income and resources, so the change in SSI policy results in a change in ABD Medicaid policy as well. Montana does not require documentation of the value of an applicant's household goods and personal effects and has assumed the value is less than \$2000. This change simply makes that assumption unnecessary. This change thus will have no fiscal impact.

MA 402-4 Conditional Assistance This section adds explanation of instances when conditional assistance can be granted retroactively. In order for the conditional assistance resource exclusion to apply to a retroactive period, the property covered by the conditional assistance benefit must have been listed for sale during the retroactive month. Property not listed for sale in the retroactive months cannot be excluded under a conditional assistance agreement. This change has no fiscal impact because the total number of months of conditional assistance is not affected. This change simply affects which months can be counted toward the conditional assistance period and so would be subject to recovery from the sale of the property.

MA 404-1 Asset Transfers This section has been amended to include provisions mandated by the Deficit Reduction Act of 2005. These provisions include expanding the look back period for asset transfers to five years for assets transferred on or after February 8, 2006 and the policy that the purchase of an annuity on or after February 8, 2006 by a Medicaid applicant/recipient or his/her spouse must be considered an uncompensated asset transfer unless the following conditions are met: annuity payments must be made to the Medicaid applicant/recipient or his/her spouse and the payments must be made in equal periodic installments with no deferrals or balloon payments, the payment schedule must be actuarially sound, the annuity must be irrevocable and nonassignable, and the state of Montana Medicaid program must be named as the irrevocable first position residual beneficiary of the annuity (with the exception that the community spouse and/or a minor or disabled/blind child can be a residual beneficiary in a position primary to the state of Montana Medicaid program). Annuities purchased by community spouses after Medicaid eligibility has been established for an institutionalized spouse, which do not meet the above criteria, will result in an asset transfer penalty being applied to the nursing home spouse, regardless of other policies that exclude asset transfers by spouses from causing ineligibility for an institutionalized Medicaid recipient.

According to a survey done in 2004, 74 individuals had applied in the past six months who had transferred assets that would have caused ineligibility under these proposed changes governing the look back period and annuities. Based on that information, if we assume these changes would affect 148 individuals annually upon full implementation in February 2011, the savings would be \$762,792 in state general fund annually---a total savings of all Medicaid dollars totaling \$2,824,876 each year. The DRA provides that the longer look back period of five years applies only to transfers made on or after February 8, 2006, the date on which the DRA was enacted. Thus, the department will still be looking back only three years until three years after February 8, 2009. The look back period will increase incrementally beginning on February 8, 2006. For example, an application submitted on March 8, 2009 will have a look back period of three years, one month, an application submitted on April 8, 2009 would have a look back period of three years, two months, and so on. The department will be able to use the full five-year look back period only for applications submitted on or after February 8, 2011. However, since the federal regulation only applies the new policy of a five-year look back and penalty beginning in the month of the individual being otherwise eligible for institutionalized or waiver Medicaid, the state will realize incremental savings in the next five years. Twenty percent of the projected savings above is anticipated in 2006-2007 (\$152,558 in General Fund/ \$564,975 in total Medicaid dollars), 40% in 2007-2008 (\$305,117 in General Fund/ \$1,129,950 in total Medicaid dollars), 60% in 2008-2009 (\$457,675 in General Fund/ \$1,844,926 in total Medicaid dollars), and 80% in 2009-2010 (\$610,234 in General Fund/ \$2,259,901 in total Medicaid dollars). Some individuals who will transfer funds will simply choose not to apply for Medicaid at all until the five-year look back has expired. Others will apply and establish their penalty period and serve it after the onset of illness. Both situations will result in cost-savings to the state.

Aside from the Deficit Reduction Act of 2005 changes, some other changes have been made as well. A statement has been added explaining that estate planning is a process designed to help manage and preserve a person's assets while alive and to conserve and control their distribution after death. For purposes of the determination of Medicaid eligibility, "estate planning" actions must be considered as specifically for preserving assets from long term care costs via Medicaid. The state believes this addition to the manual, and therefore the Administrative Rules of Montana will clarify the intention of the policy. Also, the fact that payments from trusts to or for the benefit of people or entities other than the Medicaid applicant or recipient who is beneficiary of the trust has been added to the list of actions to which the five-year look back period applies for pre-February 8, 2006 asset transfers. This requirement was in the federal law prior to the passage of the DRA but had not been included in the text of the policy manual. We do not believe that this change results in any fiscal change.

MA 404-2 Penalty Periods for Asset Transfers The Deficit Reduction Act of 2005 requires that penalties for asset transfers made on or after February 8, 2006 and within the look back period for Medicaid asset transfers, begin to apply to the Medicaid applicant/recipient only when the individual or one member of a couple

meets all of the following criteria: applies for Medicaid, is institutionalized, and meets all other Medicaid eligibility criteria. This is a change from the policy that applies to asset transfers made prior to February 8, 2006, in which the asset transfer penalty begins in the month of the asset transfer, regardless of whether the person or couple who made the transfer otherwise qualified for Medicaid, resided in an institution, or otherwise qualified for Medicaid (most did not qualify for Medicaid until later). See fiscal impact explained under MA 404-1, as the changes to these two sections are combined into that discussion.

MA 904-2 *Post-Eligibility Treatment of Income for Institutionalized Spouses* This section is amended to include the updated/increased Basic Shelter Allowance and Basic Needs Standard announced by the Centers for Medicare and Medicaid Services (CMS). The Basic Shelter Allowance and Basic Needs Standard are used in determining community spouse income maintenance allowance and family income maintenance allowance. The increased Basic Shelter Allowance and Basic Needs Standard will be used as of July 2006. Compliance with these standards is required by 42 U.S.C. 1396r-5. There is expected to be no fiscal impact because the increases merely address inflationary increases in the cost of living. The section is also being revised to clarify that a family member can only be allowed a family income maintenance allowance from one Medicaid person in any given month. This prevents duplication of this allowance, which would be against federal intent. The order of expenses allowed to offset the nursing home resident's income has been adjusted to match federal regulations. This will not affect the amount of the individual's liability toward cost of care, but recognizes that an individual's income is first used to meet the individual's needs and only then allowed to meet the needs of others. This will have no fiscal impact to the agency or state.

MA 904-3 *Post-Eligibility Treatment of Income for Institutionalized Individuals* This section is being amended to remove reference to Family Maintenance Allowance as a possible deduction for an institutionalized individual. Federal law has always limited the Family Maintenance Allowance to situations where the dependent family members are living with a community spouse, and therefore the deduction is not available to an institutionalized individual. Instead, allowable payments to dependents not living with a community spouse are limited to deductions for legally obligated child support. The provision in the current manual that allows the deduction for an institutionalized individual is incorrect. We know of no individuals in nursing homes who have dependent family members who have been using this deduction at this time. The agency does not believe this erroneous policy was every utilized while it was included in the manual, and therefore the removal of the allowance would carry no fiscal impact.

MA 907-1 *Montana State Hospital* This section is amended to include Medicaid coverage of people who attain age 21 while being treated as an inpatient at Montana State Hospital. Individuals who turn 21 while in Montana State Hospital should retain eligibility for Medicaid coverage of services through the date they turn 22 or are unconditionally released from Montana State Hospital, whichever is sooner, if they continue to meet all other financial and nonfinancial eligibility criteria for

Medicaid. This is according to 42 CFR 441.151. The Medicaid manual had previously indicated Medicaid coverage stopped for patients at Montana State Hospital at age 21. The fiscal impact to the program is expected to be as follows. Within the last year, we have had only one individual who met this exception. The net result to the state is an increase in revenue to the state, as ineligibility for these individuals results in 100% General Fund payment for services. If we assume that this would affect, at most, 12 months of eligibility for one person each fiscal year, with the daily rate at Montana State Hospital being \$383, then the total cost for one person's care is \$139,795. Federal Medicaid contribution will be roughly 70% of that, or \$97,856.50, which is a dollar-for-dollar savings to the state general fund.

MA 1501-1 Reporting Changes This section is being updated to reflect that income and resources must be verified at application, redetermination, and anytime a change is reported. Current policy is that income and resources must only be verified at application and redetermination, and that "client statement" is sufficient at all other times. This change is necessary for two reasons. The first is that state Medicaid reviewers are discovering eligibility errors caused by not requiring verification of changes in income and/or resources. The current Medicaid error rate is approximately 13%. Federal Medicaid Quality Control is slated to begin in 2008 in Montana. At that time, Montana will be expected to have an error rate of 3% or less. Implementing this change now will allow time for the state to lower the current error rate prior to federal reviews taking place. The second reason for this change is in preparation for the new Medicaid eligibility system, CHIMES (Combined Healthcare Information and Montana Eligibility System). CHIMES is a rules-based system and cannot differentiate between when it is appropriate to allow 'client statement' and when it is necessary to require other verification. Other changes to this section include adding that changes affecting coverage level must also be reported timely, and that the date reported, or coverage request date is used to determine retro eligibility for the higher coverage level. See discussion under Section FMA 1501-1 for an explanation of what is meant by a higher coverage level. Additionally, minor corrections were made to correct form and notice numbers mentioned in the section.

ARM 37.82.701 Groups Covered, Noninstitutionalized Families and Children ARM 37.82.701 is being updated to change countable resource limits for two children's Medicaid programs, as required by HB 552 codified at section 53-6-113, MCA. The resource limits for the children's poverty-related programs (known as Child-Under Age 6 and Child-Age 6 to 19) is increasing from \$3000 to \$15000 effective July 1, 2006. Increasing the resource limit is expected to allow an additional 3775 children to receive Medicaid at an estimated cost of \$7,761,272 (3775 children x \$168.24 average monthly cost x 12 months) for SFY 2007. The state share is estimated to be \$1,824,917 to be funded with State Special Revenue from I-149, the Tobacco Initiative, which increased taxes on cigarettes and tobacco products.

Other changes have been made throughout ARM 37.82.701 to update program names in preparation for the new Medicaid eligibility system, CHIMES. The program names are being changed to be more reflective of the group covered and to remove 'poverty' from them. Some program definitions have also been corrected as errors

were discovered while researching for CHIMES and from conversations with CMS (Center for Medicare and Medicaid Services) in Denver.

It was necessary to update (1)(d)(i) and (1)(e)(i) to reflect that the unborn is considered an additional filing unit member, not an additional assistance unit member as the unborn increases the household size, but does not receive Medicaid benefits.

ARM 37.82.701(1)(f)(i)(A) was updated to correct the Human and Community Services Division address.

Subsection (1)(n)(iii) was updated to reflect that the 200% FPL income limit is applicable only at the time of screening. This was necessary as income changes after initial screening by the Montana Breast and Cervical Health Program do not affect the woman's eligibility for Medicaid under the Montana Breast and Cervical Cancer Treatment Program.

Section (3) is being removed, as it is duplicative of (1)(e)(ii).

4. The department intends that the amendments to ARM 37.82.101 addressed in this notice be applied retroactively to February 8, 2006, the date on which the mandatory provisions of the Deficient Reduction Act of 2005 took effect, with the exception of the amendments to Sections FMA 001 and FMA 400 of the Family Medicaid Manual. The provisions of Sections FMA 001 and FMA 400 relate to the increase in the resource limit from \$3,000 to \$15,000 for children's poverty-related Medicaid, which was mandated by House Bill 552 to take effect on July 1, 2006. The department therefore intends that the amendments to Sections FMA 001 and FMA 400 of the Family Medicaid Manual be applied retroactively to July 1, 2006.

5. Interested persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than 5:00 p.m. on August 24, 2006. Data, views, or arguments may also be submitted by facsimile (406)444-1970 or by electronic mail via the Internet to dphhslegal@mt.gov. The department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

6. The office of legal affairs, Department of Public Health and Human Services has been designated to preside over and conduct the hearing.

/s/ Barbara Hoffmann
Rule Reviewer

/s/ Joan Miles
Director, Public Health and

Human Services

Certified to the Secretary of State July 17, 2006.